

Dias v. Dias, 3:24-CV-04471-EMC (N.D. Cal.)
EXPERT REPORT OF DR. LAURA PETRACEK

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1. QUALIFICATIONS

My name is Laura Petracek. I hold a Master of Social Work from the Wurzweiler School of Social Work. I also hold a Ph.D. from the California Institute of Integral Studies. I am also a Licensed Clinical Social Worker. I have been practicing as a licensed psychologist in California since 1986. (See CV for more.)

I specialize in Dialectical Behavior Therapy and other evidence-based therapies for alcohol and substance abuse, mood disorders, and anger issues. I also specialize in domestic violence and child custody issues. A copy of my curriculum vitae is attached as **Exhibit A**. I have not provided testimony in the last four years.

I reserve the right to supplement this report.

I am being compensated at an hourly rate of \$400 for preparing this report and an hourly rate of \$500 for preparing and providing testimony at trial (if necessary). My compensation in this matter is not contingent on the content of my opinion or the outcome of this matter.

2. ASSIGNMENT AND SUMMARY OF CONCLUSIONS

Gibson Dunn & Crutcher LLP has retained me as an expert witness on behalf of the respondent, Ms. Dias Nabi Khoury Cavaco Dias. I have been asked to provide my opinion on three topics.

Topic 1: The detrimental effects of adversity—including direct violence and exposure to domestic violence—on a child’s development.

Topic 2: Whether I.D., N.D., and C.D. (“the Children”), aged nine (9), eight (8), and six (6) years old, present symptoms of trauma.

Topic 3: Whether returning children with symptoms such as those that I.D., N.D., and C.D. have presented to an environment where they could be subjected to violence against them or against their mother by their father for even a short period poses a risk of further—and potentially permanent—adverse effects on the children’s development.

Children who witness domestic violence are significantly affected by emotional and psychological abuse, leading to a range of detrimental outcomes. Exposure to domestic violence disrupts their sense of safety and security, which is crucial for healthy emotional development.

1. **Emotional Dysregulation:** Children exposed to domestic violence often struggle with regulating their emotions. They may experience heightened anxiety, aggression, and mood swings as the chaotic environment prevents them from developing healthy coping mechanisms. This emotional dysregulation can lead to difficulties in social interactions and relationships later in life.
2. **Impact on Attachment:** Witnessing violence can severely disrupt attachment

processes. Secure attachment with caregivers is essential for emotional stability; however, when children see one parent victimized or made to feel unsafe, their ability to form secure bonds is compromised. This can result in insecure attachments and difficulties trusting others.

3. **Cognitive and Behavioral Issues:** Research indicates that children who witness domestic violence are at a higher risk for cognitive impairments and behavioral problems. They may exhibit difficulties in concentration and learning, manifesting in academic challenges (Kitzmann et al., 2003). Behavioral issues may include increased aggression and defiance, as children may imitate the violent behavior they observe.
4. **Long-term Psychological Effects:** The emotional abuse experienced by these children can have lasting implications, contributing to conditions such as depression, anxiety disorders, and post-traumatic stress disorder (PTSD) (Kitzmann et al., 2003).
5. **Intergenerational Effects:** The emotional and psychological effects of witnessing domestic violence can perpetuate cycles of abuse. Children who grow up in such environments may be more likely to become involved in abusive relationships as adults, either as victims or perpetrators, continuing the cycle of violence (Jaffe, Wolfe, & Wilson, 1990).

Separately, I have also evaluated Ms. Dias and her three children. I have been treating Dias and the three minor children—I.D. (9 years old), N.D. (8 years old), and C.D. (6 years old)—together “the Children,” since early May 2024. Ms. Dias hired me in May 2024, upon the family’s arrival in the United States, to treat both the Mother and the Children for any potential trauma they faced due to the alleged abuse by Mr. Dias.

I have conducted more than a dozen therapy sessions with each child and at least six with Ms. Dias. I have also reviewed Ms. Dias’s medical records, her police witness statements, photographs of her injuries, and police reports from Armenia documenting incidents of violence and threats by Mr. Dias. I have also reviewed numerous text messages sent by Mr. Dias to Ms. Dias before, during, and after the incidents. On July 11, 2024, I observed the Children in their home environment, how Ms. Dias interacted with them, and her parenting style.

I have conducted a range of evidence-based assessments of Ms. Dias and the Children to assess symptoms of trauma. (See BASC 3 evaluations.)

3. THE DEVELOPING CHILD

3.1 The Developing Brain

a) Research on Domestic Violence and its Impacts on Childhood Development

Infants depend on secure attachments for healthy emotional development, but exposure to domestic violence can disrupt caregiver responsiveness, leading to insecure attachments

that may impact future relationships. Additionally, infants in violent environments often show heightened stress responses, and chronic stress can alter brain development, particularly in regions responsible for emotional regulation.

Similarly, children exposed to domestic violence may experience delayed language development, as the lack of positive verbal interaction and emotional engagement with caregivers can hinder their ability to develop communication skills. Additionally, these children may struggle with social interactions, exhibiting excessive clinginess or withdrawal due to disrupted attachment patterns (Fantuzzo, J. W., & Mohr, W. K., 1999).

Exposure to violence can impair children's ability to regulate their emotions, leading to heightened anxiety, aggression, or difficulty understanding their feelings. Additionally, play, which is crucial for development, may be affected, with children from violent households often displaying aggressive play patterns or withdrawal, which can hinder their learning and socialization in preschool settings.

Chronic exposure to domestic violence can affect children's cognitive development, leading to difficulties with concentration and academic tasks, often resulting in learning challenges. Additionally, these children may exhibit increased aggression, defiance, and attention-seeking behaviors, along with symptoms of anxiety or depression (Jouriles, E.N., et al., 2009).

As children from violent homes begin to form deeper friendships, they may struggle with trust, often avoiding social interactions or engaging in conflicts with peers. Witnessing domestic violence can also lead to low self-esteem and feelings of worthlessness, further affecting their ability to navigate social situations successfully (Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D., 2003).

Adolescents exposed to domestic violence often struggle with identity development and self-worth, which can lead to risky behaviors such as substance abuse or delinquency. The trauma from this exposure can also result in serious mental health issues, including depression, anxiety disorders, and an increased risk of suicidal thoughts or actions.

Children who witness domestic violence are at a higher risk of experiencing or perpetrating violence in their future relationships. Studies show a correlation between childhood exposure to domestic violence and long-term challenges in mental health, academic achievement, and social functioning (O'Keefe, 1998).

Understanding the relationship between domestic violence and childhood development stages is crucial for developing effective interventions.

3.2 Environmental Factors for Favorable Brain Development

a) Research on Childhood Development Relevant to Children's Stages of Development

Child development is a complex process that occurs through distinct stages, each with

unique emotional, cognitive, and social milestones. When children are exposed to adverse environments, such as domestic violence, their development can be significantly disrupted. Below is a detailed exploration of these stages, grounded in research on childhood development and trauma, emphasizing the specific vulnerabilities and impacts associated with each developmental phase.

During infancy, children build trust with caregivers through secure attachment (Bowlby, 1969). Trust forms the foundation for later emotional and social development. Infants are susceptible to the emotional climate of their environment, even if they cannot fully comprehend events. Exposure to domestic violence at this stage can disrupt attachment and lead to increased crying, sleep difficulties, and developmental delays (Zeanah et al., 1999). Research suggests that infants exposed to trauma may also experience elevated cortisol levels, which can impair brain development (Gunnar & Donzella, 2002).

As they grow, children learn to regulate emotions during early childhood (infancy to approximately age 6) and engage in social interactions. According to Erikson's psychosocial theory, children in this stage are in the "Autonomy vs. Shame/Doubt" and "Initiative vs. Guilt" phases, where they seek independence and learn about consequences. Domestic violence exposure can lead to difficulties with emotional regulation, excessive fear, and behavioral regressions (Erikson, 1963). Piaget's cognitive theory places children in the preoperational stage at this age, where they engage in symbolic play but may misinterpret the cause of conflict, often blaming themselves for parental disputes (Piaget, 1952).

Children at this age may also begin to display aggressive or withdrawn behaviors due to witnessing violent behavior, as suggested by Bandura's social learning theory (Bandura, 1977). These children might emulate the violence they see, believing it is a normative way to handle conflicts.

In middle childhood (approximately age 6 through 12), cognitive abilities expand, and children develop more vital logical reasoning skills, entering Piaget's concrete operational stage. They understand complex social relationships and moral reasoning (Kohlberg, 1981). Children exposed to domestic violence during this period often face academic difficulties and struggle with social relationships, either becoming overly aggressive or excessively withdrawn (Edleson, 1999). This is a critical period for self-esteem and peer acceptance, and children who live in violent homes may experience social isolation or bullying (Fantuzzo & Lindquist, 1989).

Research shows that chronic stress, like that caused by exposure to violence, can impede cognitive functions such as attention and memory (Shonkoff & Garner, 2012). The cumulative effect of these developmental disruptions can contribute to long-term emotional and academic challenges.

The search marks adolescence (approximately age 13 to 18) for identity and autonomy and the development of more abstract thought processes. According to Erikson, the critical developmental task during this stage is "Identity vs. Role Confusion" (Erikson, 1963). Adolescents exposed to domestic violence may struggle with identity formation, often engaging in risk-taking behaviors like substance abuse or early sexual activity as coping mechanisms (Litrownik et al., 2003). Additionally, the trauma from earlier exposure to

violence may manifest as anxiety, depression, or even PTSD (Wolfe et al., 2003).

Adolescents may also begin to experience or perpetrate violence in their intimate relationships, mimicking the unhealthy dynamics they have witnessed at home (O'Keefe, 1998). The risk of emotional disorders, such as depression and suicidal ideation, increases significantly during this stage for those exposed to trauma, making adolescence a particularly vulnerable period (Evans et al., 2008).

The effects of witnessing or experiencing domestic violence vary according to the developmental stage of the child, but the adverse outcomes often accumulate over time. Early disruptions in attachment can lead to emotional dysregulation, while cognitive impairments become more evident in school settings. Social learning theory highlights the risk of children normalizing violence, leading to interpersonal difficulties later in life.

Understanding the unique needs of children at different developmental stages can help guide more effective interventions. Developmentally appropriate support can mitigate the negative impact of trauma, foster resilience, and promote healthier emotional and cognitive development.

4. EXPOSURE TO INTIMATE PARTNER VIOLENCE (“IPV”) HAS HARMFUL EFFECTS ON CHILDREN

4.1 Research on Domestic Violence and Children

Mental health professionals are keenly aware that domestic violence, defined as abuse between intimate partners, is a major social problem. National surveys indicate that 10 to 20 million adults are victims of intimate partner violence each year. For total assaults, including minor types such as pushing and grabbing, victims are equally divided between men and women (Straus et al., 1990). Women are just as likely as men to initiate, and we know that mutual assaults occur in 50%–85% of violent relationships (Straus, 1996; Langhinrichsen-Rohling et al., 1995). We also know that only 10%–22% of physical assaults are carried out in self-defense, and that attempts to “get through” to one’s partner or retaliate for a perceived wrong are much more frequent motives (Sommer, 1994; Carrado et al., 1996). Due to their smaller size, women suffer approximately 65% of total physical injuries and up to 75% of severe injuries (Tjaden & Thoennes, 1998; Archer, 2000). Men are also far more capable of using physical coercion and threats of violence as a means of controlling their partners.

Adults are not the only victims. At least 10 million children are exposed to marital violence each year (Straus et al., 1980). Most of them, it appears, are fully aware of most of the fighting (Holden & Ritchie, 1991). Law enforcement agencies report high numbers of child witnesses to domestic violence. For instance, the Sheriff’s office in Contra Costa County, California, noted that in official spousal abuse cases covering a period from January 1 through September 30, 2000, children were present 73% of the time (Contra Costa Office of Sheriff, 2000). Research by Fantuzzo & Lindquist (1989) reveals that children raised in homes where the father has physically abused the mother are at a 30%–40% higher risk

than children from nonviolent homes for psychopathology. These children are also at higher risk than children who have only been exposed to neighborhood violence (Litrownik et al., 2003). Literature reviews suggest that children exposed to marital violence are at risk for exhibiting a host of internalizing and externalizing symptoms and social and school problems. These symptoms, similar to those suffered by children who have experienced direct physical abuse, include poor self-esteem, anxiety, depression, stress trauma symptoms, aggression, oppositional-defiant behavior, substance abuse, poor social skills, lack of empathy, poor academic performance, truancy, somatic problems, and obsessive-compulsive traits (Kolbo et al., 1996; Wolak & Finklehor, 1998; Edleson, 1999).

Children are differentially affected by their parent's marital violence, depending on their age. Toddlers are generally the most distressed (Jaffe et al., 1990). A gender effect (e.g., whether or not boys have more externalizing problems and girls have more internalizing issues) has not been established, but overall, these symptoms are equally prevalent (Kitzmann, 2003). We know that, for all children, witnessing marital violence has a continuous, cumulative effect. Children who have seen such violence, especially severe assaults, become sensitized rather than habituated over time and are re-traumatized whenever there is an incidence of *any* marital conflict (Holden, 1998).

Johnston & Roseby (1997) examined in much greater detail the effects of partner abuse on children, extending their research beyond a mere description of symptomology to a systemic investigation of family dynamics, boundaries, and alliances. The results, from extensive interviews, as well as a battery of psychological tests with 160 separated or divorcing couples and their children, were further categorized according to the type of marital violence they witnessed (Johnston & Roseby, 1997):

Ongoing/Episodic Male Battering. In these families, the man dominates the woman with extreme verbal and physical abuse in the classic three-phase cycle of build-up, battering event, and repentance. Younger daughters are passive and fearful, clingy with mothers. Fathers may lavish attention on these girls, sometimes in a seductive, sexualized manner, but at other times will ignore them. This causes them to have a dual image of their father, as both loving and scary. Fathers seek affirmation of their self-esteem from these younger daughters, who “become watchful and oriented toward attempting to manage the father’s equilibrium and anger” (Johnston & Roseby, 1997, p. 31). Older, school-age girls are more likely to take it upon themselves to protect their mothers by subtly influencing and managing fathers. Some resent the mother for not standing up for herself. Younger boys display oppositional and aggressive behavior towards their mothers. At the same time, they worry about her safety. Older boys are afraid of Dad but also attracted to his power in the family. They are angry with him because of his marital and parental violence and his unavailability, but they cannot show this overtly. Instead, they often turn on their mothers, behaving like their dads. In many cases, when mom leaves dad, the children usually idealize him, repress memories of his violence, and blame mom for his absence.

Male-Controlling Interactive Violence. Partner violence of this type is mutual, but Dad, due to his greater size and strength, is usually able to gain the upper hand in a physical fight that has gotten out of control. Children in these families exhibit a range

of reactions, but aggression and passive-aggression are the primary ones. Because of the dual violence, children are left with no positive role model to cope with stress and conflict successfully. They are conflicted, and their alliances shift back and forth between the parents. Boys, including moms, may develop a total lack of respect for authority. "Fathers often have peer-like relationships with their sons, especially as they grow older... Fathers are inclined to admire their son's toughness and acting out, as the son replaces the father around the house." (Johnston & Roseby, 1997, pp. 37-38)

Separation-Engendered and Post-divorce Trauma. In this typology, the parents have no significant history of physical assaults upon each other but act out around the time of separation. Parents, Johnston found, typically align with the same-sex offspring. Because of the unexpected nature of the violence, children sometimes show symptoms of PTSD, which may include fearfulness and nightmares. However, due to the parent's relative strength and parenting abilities, these children are more able than those in other violent households to overcome their symptoms and eventually heal.

4.2 Partner Abuse and Child Abuse

The effects of partner violence on children should give us cause for alarm. However, assaults by other family members are far more frequent (Straus et al., 1980). Parents perpetrate severe assaults on their children at a rate of 11 per 100. What are the effects of these other forms of violence, and how do they interact? As the Johnston and Roseby research indicates, we cannot ignore the reciprocal nature of relationships or that events in one part of the system reverberate throughout the whole. A well-known finding, for instance, is that children who witness their parents fight are at high risk of being assaulted themselves and that parents who physically abuse their children are more likely to perpetrate spousal abuse (Straus et al., 1990). Another consideration is the relationship between family violence and general dysfunction. A literature review reveals several significant trends but no definitive answers.

Salzinger et al. (2002), examining 100 cases of physically abused children in New York City, ages 9-12, determined that the effects of having experienced direct child abuse were more significant than having witnessed violence between the parents. In a study conducted the following year with a cohort of 261 preschool children referred to CPS for child abuse and neglect, English et al. (2003) found similar results. However, according to the most recent, comprehensive meta-analysis of the literature conducted by Kitzmann and her colleagues (2003), the *overall* impact, in terms of both internalizing and externalizing symptoms, of a child having experienced direct parental abuse is no greater than a child having witnessed marital violence.

In a study by Hershorn & Rosenbaum (1985), children from discordant but nonviolent homes were determined to be just as aggressive and oppositional as those of battered women. In a study by Grych & Fincham (1990), children from violent and discordant families exhibited similar internalizing and externalizing symptoms.

Subsequently, Fantuzzo et al. (1991) compared a group of battered women and their children living in a shelter with battered women and their children still living at home and a non-violent control group. Children from both types of violent settings exhibited more externalizing problems than children from non-violent homes. However, the shelter children exhibited more internalizing symptoms than the home-violent group. According to Fantuzzo et al., the results of that study suggest a direct relationship between interparental conflict and familial disruption and the nature of child adjustment problems for young children. In this respect, (1) verbal conflict only was associated with a moderate level of conduct problems; (2) verbal plus physical conflict was associated with clinical levels of conduct problems and a moderate level of emotional issues; and (3) verbal plus physical conflict plus temporary shelter residence was associated with clinical levels of conduct problems, higher level of emotional issues, and lower levels of social functioning and perceived maternal acceptance (Fantuzzo et al., 1991, p. 263).

According to Wolak & Finklehor (1998), “Pervasive conflict that takes the form of overt verbal hostility or violence harms children by causing stress, impairing effective parent-child relationships, and training children to be aggressive. Overall, children from violent homes appear to be at greater risk for showing clinical-level behavioral and emotional problems. Still, some symptoms are likely caused by the conflict and not necessarily the violence” (pp. 91-92). The authors propose that the harmful effects of marital violence may be direct or indirect. Direct effects include physical danger (from being around thrown objects, etc.) and psychological trauma leading to internalizing and externalizing symptoms. Indirect effects include the harsh parenting associated with marital violence and other poor parenting practices such as inconsistency, low positive involvement, and attachment disturbance. They also include the accumulated stress that children take on due to the stress, anxiety, and depression experienced by maritally violent parents, as well as the attendant problems of substance abuse, economic difficulties, and relationship breakups.

Even the *possibility* of divorce is traumatic to children. Laumakis et al. (1998) examined the differential impact of physical marital aggression, negative tone, verbal put-downs, and threats to leave on children. Seventy-four children listened to staged audio fights between couples. A sophisticated coding system allowed the children to respond in their own words rather than choose from a list of response choices. The most negative emotional reactions were given by children who had listened to couples either physically fight or threaten to leave. The finding that threats to leave caused as vital a reaction as physical violence or verbal abuse was significant, according to the authors:

Why are physical aggression and threats to leave more upsetting than conflicts with name-calling and negative voice qualities? *The key feature of these two scenarios is the implied impact on the child by the potential for significant disruption and change in the marriage and family life as the child knows it.* These data lead one to examine more closely the commonly stated assumption that exposure to marital aggression and violence is more upsetting than exposure to other forms of marital conflict (p. 280).

Families, by their very nature, produce high levels of conflict. Many tasks must be carried out, including income generation, household chores, and raising children. At the same time, it is within the family that one seeks to meet such basic emotional needs as belonging and self-esteem. And yet, families are made up of individuals from different generations, at

various developmental levels, and with competing demands and interests. This results in high levels of stress. In combination with poor impulse control and insufficient problem-solving skills, family stress can lead to intense conflicts and sometimes physical violence among the various family relationships - parent and parent, parent and child, child and child. The family, according to Straus et al. (1990), is “the most violent institution a citizen is likely to encounter.” This is mainly due to the higher tolerance for violence in families, especially corporal punishment. We know, for instance, that parents who use corporal punishment are at higher risk of crossing the line into physical child abuse (Straus & Donnelly, 2001). And parents who permit themselves to hit their children are far more likely to turn their aggression against their spouses.

The family has different rules about violence than do other groups. In an academic department, an office, or a factory, the basic rule is that no one can hit anyone else, no matter what they do wrong. A person can be a pest, an intolerable bore, negligent, incompetent, selfish, or unwilling to listen to reason. But that still does not give anyone the right to hit such a person. In the family, the situation is different. There, the basic rule is—at times and especially in more tradition-focused families—that if someone does wrong and won’t listen to reason, violence is permissible and sometimes even required (Straus et al., 1990, p. 184).

Although some types of assaults are more likely to cause physical injury than others (e.g., husband-on-wife, parent-on-child), *any* use of violence is destructive. Violence inflates stress to higher levels and tends to beget more violence, thus gravely undermining the family’s ability to carry out its functions. Children growing up in such an environment learn that violence is an acceptable way to resolve problems. More importantly, they know that love and abuse tend to go together. As adults, these children are far more likely than those from non-violent homes to become involved in pathological, dependent relationships and become abusive themselves, thus transferring the cycle from one generation to the next. Domestic violence, therefore, cannot be understood outside of a family context.

In Wolak & Finklehor’s analysis, there was a correlational relationship between marital violence, family dysfunction, physical child abuse, and the various internalizing and externalizing symptoms suffered by children. Other researchers have proposed a direct causal link between these phenomena, with husband-on-wife battering as the primary cause. Holden & Ritchie (1991) compared 37 battered women with 37 women from non-abusive households. The battered women were observed to engage in more conflicted, negative interactions and were less involved with their children than those in the comparison group. Because maternal stress and paternal irritability were the strongest predictors of child behavior and emotional problems, the authors concluded that there is a “spillover” effect from the marital violence that affects parenting by both parents.

Moore and Pepler (1998) conducted an ambitious study with four groups of latency-age children and their mothers: 113 in a battered women’s shelter, 82 homeless families in temporary housing, 82 single-parent families (mother only), and 100 intact, two-parent, non-violent families. Mothers were administered the CTS, the General Health Questionnaire, and the Child Behavior Checklist (measuring children’s internalizing, externalizing, and social problems). The children were given the WRAT-R (academic achievement), the Digit Span subscale of the WISC (memory), and the Children’s Locus of Control Scale. The

authors found that low income, less parental education, frequent moves, and poor maternal health were characteristics of both shelter and homeless families. The shelter and homeless children scored significantly lower in social competence than those from two-parent families and scored much lower on the Digit Span test. The homeless children scored more than one standard deviation below grade level on the Reading and Math tests of the WRAT-R.

Thus, marital abuse is seen by some as the primary source of stress in families of battered women and the cause of both child abuse and its consequences. Furthermore, there is an equal likelihood that marital discord and violence *follow*, rather than precede, parent-on-child conflict. Lynch & Cicchetti (1998) determined that the existence of child behavior problems *before* having been exposed to marital violence contributes significantly to overall levels of family stress, which in turn may aggravate both marital and parent-child relationships. We have seen how attitudes favorable to corporal punishment are associated with pro-violent attitudes towards spouses (Straus et al., 1990; Straus & Donnelly, 2001). We should be careful when making unwarranted generalizations. In a study of 110 Israeli families, Sternberg et al. (1993) found that children who were both witnesses to marital violence and had experienced physical child abuse did not suffer more psychological damage than children who had only witnessed marital violence or children who had only been directly abused. In their literature review, Kitzmann et al. found similar results. “Violence *anywhere* in the family,” the authors suggested, “may be sufficient to disrupt child development” (p. 346).

A New York City study by Salzinger et al. (2002) sought to identify the relative effects of family stress, partner violence, caregiver distress, and child abuse on children’s development. Caregiver distress was not found to be a function of partner violence. Partner violence was a mediator of child abuse, not by directly producing poor functioning in the child but rather by increasing the risk of aggression against the children. Amongst all the variables, the authors identified two significant causal paths. In one, family stress increases the risk of partner violence, which increases the possibility of child abuse. On the other, family stress contributed to caregiver distress, which in turn led to child abuse. In looking at the impact of exposure to marital violence on children, she found that the effect size in studies that controlled for family stress was smaller than in those that did not. Amongst the factors hypothesized to impact child functioning negatively, general family stress is the most significant and can exacerbate other conditions. In this conception, partner violence is merely one, albeit important, factor in family dysfunction.

4.3 Effects on Adult Functioning

The effects of intimate partner violence unfortunately persist well into adulthood, when the child grows up and becomes involved in an intimate relationship. We know that children from abusive families are more likely than children from non-abusive families to exhibit aggressive behaviors later in life. The mechanisms by which this behavior is thought to be transmitted fall into two categories. In the first, children learn to become violent through observational learning. For instance, men who witness intimate partner violence in childhood are more likely to commit such acts in adulthood, compared with men who are otherwise similar with respect to a large range of potential confounders. (Roberts et al., 2010). For violent women, the assault rates are generally the same whether they have seen

violence by the father, by the mother, or both. Violent men, however, are more likely to have witnessed violence by the mother upon the father.

The other mechanism involves the effects of child abuse and neglect. Litrownik and his colleagues (2003) conducted a prospective study from a nationwide sample of 682 abused children, comparing data from interviews at age four and age 6. Among their findings were that psychological child abuse predicted internalizing symptoms of anxiety and depression, whereas a combination of physical and mental child abuse predicted aggressive behavior. These findings dovetail with more recent studies on the intergenerational transmission of violence. Working with a population of men convicted of spousal battering, Dutton (1998) found that those who had experienced rejection, insecure attachment, shaming, and other forms of emotional abuse tended to become rageful, emotionally abusive, but often non-violent adults. In contrast, men who have experienced all of these, in combination with having witnessed *or* having directly experienced physical abuse, tend to become emotionally abusive, controlling, *and* physically violent.

5. DIRECT ABUSE HAS HARMFUL EFFECTS ON CHILDREN

Direct abuse, whether physical, emotional, sexual, or neglectful, has profound and often long-lasting impacts on child development. Abuse disrupts normal developmental processes, leading to a wide range of emotional, psychological, and physical problems that can persist into adulthood. This research highlights how various forms of direct abuse affect different domains of child development, focusing on cognitive, emotional, and social outcomes.

5.1 Physical Abuse

Physical abuse during childhood can have immediate and long-term effects on both physical health and psychological well-being. Research shows that children who are physically abused tend to exhibit higher levels of aggression, behavioral problems, and difficulties in forming healthy peer relationships (Dodge et al., 1990). Physical abuse also increases the likelihood of developing emotional disorders such as depression, anxiety, and PTSD (Kolko, 2002).

Additionally, children who are physically abused may experience cognitive delays and perform poorly in academic settings due to the stress and trauma they endure. Chronic exposure to physical abuse is linked to impairments in executive function, including difficulties with attention, memory, and problem-solving (De Bellis et al., 2009). The body's physiological response to trauma, particularly the release of stress hormones like cortisol, can damage brain structures responsible for these functions.

5.2 Emotional Abuse

Emotional abuse, which includes verbal assaults, humiliation, and constant criticism, is often less visible than physical abuse but can be equally or more damaging. Research shows that emotional abuse has pervasive effects on a child's self-esteem and emotional regulation (Glaser, 2002). Emotionally abused children often struggle with feelings of worthlessness, shame, and inadequacy, which can contribute to long-term mental health

issues such as depression, anxiety, and borderline personality disorder (Wright et al., 2009).

Children subjected to emotional abuse may also develop maladaptive coping mechanisms, such as dissociation or avoidance, which can impair social and emotional functioning (Teicher et al., 2006). These children often have difficulty forming secure attachments with caregivers and peers, leading to problems with intimacy and trust in adult relationships.

5.3 Neglect

Neglect, characterized by the failure to meet a child's basic physical, emotional, and educational needs, can have equally detrimental effects on development. Neglected children often show developmental delays, particularly in language, cognitive skills, and social-emotional functioning (Hildyard & Wolfe, 2002). The lack of stimulation and nurturing in early childhood impairs brain development, leading to long-term cognitive deficits (Perry, 2002).

Emotionally neglected children may exhibit attachment disorders, such as reactive attachment disorder (RAD), where they are unable to form healthy emotional bonds with others. These children often struggle to regulate emotions and may become overly withdrawn or excessively dependent on others. The long-term effects of neglect can include low self-esteem, chronic depression, and an inability to maintain stable relationships in adulthood.

The cumulative effects of abuse, especially when multiple forms are experienced, can lead to complex trauma characterized by long-term psychological distress and pervasive impairments in emotional, social, and cognitive functioning (van der Kolk, 2005). Children who are exposed to chronic abuse are at higher risk for developing psychiatric disorders, substance abuse, and difficulties in forming and maintaining healthy interpersonal relationships.

Research has also shown that childhood abuse is a significant risk factor for developing chronic health problems in adulthood, including cardiovascular disease, obesity, and autoimmune disorders (Felitti et al., 1998). The chronic stress of abuse disrupts the body's regulatory systems, leading to inflammation and other physiological changes that contribute to these health outcomes.

Direct abuse has severe and far-reaching effects on child development, impacting cognitive, emotional, social, and physical health. Each form of abuse carries its own unique risks. Still, all forms of abuse disrupt normal developmental processes and contribute to a range of adverse outcomes that can persist into adulthood. Early intervention and trauma-informed care are critical in mitigating these effects and helping children recover from the devastating impact of abuse.

6. EXPOSURE TO IPV AND DIRECT VIOLENCE CAN RESULT IN PSYCHOLOGICAL AND BEHAVIORAL PROBLEMS

6.1 Exposure to IPV Can Result in Psychological and Behavioral Problems

a) **Research on Psychological and Behavioral Problems in Children Exposed to Intimate Partner Violence (IPV)**

Children exposed to intimate partner violence (IPV) are at risk of developing a range of psychological and behavioral problems, often as a result of the trauma associated with witnessing violence in their homes. Research has demonstrated that exposure to IPV can have detrimental effects on a child's emotional, cognitive, and social development, which can persist into adolescence and adulthood.

Key Psychological and Behavioral Impacts:

1. Emotional and Psychological Distress

- **Anxiety and Depression:** Children exposed to IPV show elevated levels of anxiety and depression. The trauma associated with witnessing violence can create a sense of insecurity and fear, contributing to chronic emotional distress (Evans et al., 2008).
- **Post-Traumatic Stress Disorder (PTSD):** Many children who witness IPV develop symptoms of PTSD, including hypervigilance, flashbacks, and nightmares. Exposure to violence creates ongoing psychological trauma, which manifests in both emotional and behavioral disturbances (Kitzmann et al., 2003).
- **Emotional Dysregulation:** Children exposed to IPV often experience difficulty regulating their emotions. This is linked to disruptions in brain areas like the amygdala and prefrontal cortex, which are involved in emotional control (Margolin, 2005).

2. Behavioral Problems

- **Aggression and Conduct Problems:** Exposure to IPV is associated with increased aggression, defiance, and conduct disorders in children. They may model the aggressive behavior they witness at home or express frustration through disruptive behaviors in school and social settings (Graham-Bermann & Perkins, 2010).
- **Substance Abuse and Risk-Taking Behaviors:** Adolescents exposed to IPV are more likely to engage in risky behaviors, including substance abuse, early sexual activity, and criminal behavior. This is often a coping mechanism or a way to gain control in an otherwise chaotic and unpredictable environment (Felitti et al., 1998).
- **Difficulties in Peer Relationships:** Children exposed to IPV may have trouble forming healthy relationships with peers. They may struggle with trust and emotional connection or display aggression in social interactions (Gewirtz & Edleson, 2007).

3. Cognitive and Academic Difficulties

- **Impaired Cognitive Function:** The chronic stress and trauma associated with witnessing IPV can impair cognitive functioning, leading to difficulties in concentration, memory, and problem-solving. These cognitive deficits can negatively affect academic performance and result in poor school outcomes.
- **Lower Academic Achievement:** Children who witness IPV often perform

worse academically compared to their peers. The psychological trauma they experience can interfere with their ability to focus and succeed in school, leading to lower grades and higher rates of absenteeism (Fantuzzo & Mohr, 1999).

4. Long-Term Psychological Consequences

- **Increased Risk of Mental Health Disorders:** Long-term exposure to IPV can lead to an increased risk of developing mental health disorders such as depression, anxiety, and PTSD in adulthood. Many individuals who grow up in violent households struggle with the psychological effects of their experiences for years after the violence ends (Holt et al., 2008).
- **Intergenerational Transmission of Violence:** Children who witness IPV are more likely to perpetrate or become victims of intimate partner violence in adulthood. This cycle of violence is perpetuated through learned behaviors and unresolved trauma (Ehrensaft et al., 2003).

The psychological and behavioral impacts of IPV exposure in children are profound and multifaceted. Children who witness violence are at risk of emotional dysregulation, mental health disorders, and various behavioral issues, which often persist into adulthood. Early intervention and trauma-informed support are critical in helping these children process their experiences and break the cycle of violence.

6.2 Witnessing IPV Alters the Brain and Hurts IQ

a) Impact of Witnessing Intimate Partner Violence (IPV) on the Visual Cortex

Research has shown that children exposed to intimate partner violence (IPV) can experience significant changes in brain development, particularly in areas related to visual processing. Witnessing IPV not only affects emotional and psychological well-being but also has tangible effects on neural structures, including the visual cortex.

Key Findings:

1. **Neurological Changes:** Studies indicate that exposure to violence in childhood can lead to alterations in brain structure and function. The visual cortex, responsible for processing visual information, may exhibit reduced activation and structural changes due to chronic stress and trauma associated with witnessing IPV.
2. **Impaired Visual Processing:** Children who witness IPV often display difficulties in visual processing tasks. This can manifest as challenges in recognizing facial expressions, interpreting visual cues, and responding appropriately to social stimuli, which are critical for healthy interpersonal interactions.
3. **Stress Response:** Chronic exposure to stressors like IPV can result in heightened levels of cortisol, the body's primary stress hormone. Elevated cortisol levels have been linked to changes in brain regions, including the visual cortex, potentially impairing its development and function (Lupien et al., 2009).
4. **Visual Attention and Memory:** Research suggests that children exposed to IPV may have impaired visual attention and memory. These deficits can hinder their

ability to engage with their environment and can affect academic performance, social interactions, and overall quality of life (De Bellis et al., 2009).

5. **Long-Term Consequences:** The impact of witnessing IPV on the visual cortex and related cognitive functions can lead to long-term developmental issues. Children may struggle with emotional regulation, social skills, and academic achievement, which can perpetuate cycles of trauma and dysfunction in later life (Kitzmann et al., 2003).

b) **Witnessing IPV Damages the Auditory Cortex**

Research indicates that exposure to IPV can have significant negative effects on various brain structures, including the auditory cortex. The auditory cortex, responsible for processing auditory information, may be impacted due to heightened stress responses and chronic exposure to hostile environments. Specifically:

- Chronic stress, such as witnessing violence, can result in overactivation of stress pathways in the brain, leading to functional and structural changes in the auditory cortex. This can impair a child's ability to process and interpret sounds accurately, potentially contributing to heightened sensitivity or abnormal responses to loud or aggressive auditory stimuli.
- Studies have shown that children exposed to IPV often develop hypervigilance and heightened awareness of sounds associated with violence, such as shouting or sudden loud noises. This hypervigilance may be linked to changes in the auditory cortex, which becomes conditioned to overreact to certain auditory triggers, further reinforcing trauma symptoms.
- Functional MRI studies on children exposed to chronic stress and trauma have revealed altered connectivity between the auditory cortex and other brain areas, like the amygdala and prefrontal cortex, regions involved in emotional regulation and threat assessment. This altered connectivity may contribute to difficulties in emotional processing and increased anxiety in response to auditory cues.

These findings suggest that exposure to IPV can cause detrimental effects on brain development, particularly affecting how children perceive and respond to sounds, ultimately influencing their emotional and behavioral health (Teicher & Samson, 2016).

c) **Research on Witnessing IPV Alters the Brain and Negatively Impacts IQ**

Children exposed to IPV in the home, even as witnesses rather than direct victims, experience significant developmental challenges. Research indicates that the chronic stress and trauma of witnessing violence can alter brain development and negatively affect cognitive abilities, including IQ. These changes are often mediated by stress-induced hormonal responses, particularly the overactivation of the hypothalamic-pituitary-adrenal (HPA) axis and increased cortisol levels, which interfere with brain functioning and development.

When children witness IPV, their brains respond similarly to how they would if they were directly experiencing abuse. Repeated exposure to violence triggers the body's stress response, leading to the release of cortisol and other stress hormones. Over time, chronic

exposure to high cortisol levels can damage brain areas crucial for cognitive and emotional regulation, such as the prefrontal cortex, hippocampus, and amygdala (McCrory et al., 2011).

- **Prefrontal Cortex:** The prefrontal cortex, responsible for higher-order functions like reasoning, problem-solving, and impulse control, is particularly vulnerable to the effects of chronic stress. Research has shown that children exposed to violence often have impaired executive functioning, which manifests as difficulties with attention, decision-making, and self-regulation (Pechtel & Pizzagalli, 2011).
- **Hippocampus:** Stress can adversely affect the hippocampus, which is involved in memory and learning. Studies reveal that children exposed to chronic stress or trauma, including IPV, often have smaller hippocampal volumes, leading to deficits in learning and memory (Lupien et al., 2009).
- **Amygdala:** The amygdala, which regulates emotional responses like fear and aggression, can become overactive in children exposed to violence. This overactivation can result in heightened emotional reactivity, anxiety, and difficulties in emotional regulation (McLaughlin et al., 2014).

d) **Impact on IQ and Cognitive Development**

The cognitive impairments caused by chronic exposure to IPV often extend to measurable decreases in IQ. Several studies have linked witnessing IPV to lower IQ scores in children, with some research suggesting reductions of up to 8 to 10 points in comparison to children not exposed to such violence (Koenen et al., 2003). The mechanisms driving this decline are multifaceted, involving structural changes in the brain and disruptions in cognitive functioning.

- **Stress and Cognitive Development:** Chronic stress response system activation interferes with the brain's ability to form and maintain synaptic connections, essential for learning and intellectual development. This interference can result in difficulties with language acquisition, problem-solving, and academic achievement (Evans & English, 2002).
- **Attention and Memory Deficits:** Children exposed to IPV are likelier to experience attention deficits and memory problems, contributing to lower IQ scores. These deficits make it difficult for children to concentrate in school, retain information, and perform well on standardized intelligence tests (Delaney-Black et al., 2002).
- **Environmental and Social Factors:** The chaotic and unsafe environment often associated with IPV exposure can further hinder cognitive development. Children who witness IPV may experience frequent disruptions in schooling, lack of parental support for learning, and additional stressors such as poverty, all of which contribute to cognitive delays and reduced academic achievement (Fantuzzo & Mohr, 1999).

The long-term impact of witnessing IPV on cognitive and emotional development can extend into adulthood. Adults who were exposed to IPV as children are more likely to experience mental health issues, including depression, anxiety, and PTSD, and often have difficulties with relationships and emotional regulation. These adults may also have lower educational attainment and face greater challenges in professional settings due to the cognitive impairments they experienced during childhood (Anda et al., 2006).

Witnessing intimate partner violence can profoundly impact a child's brain development and cognitive abilities. The chronic stress associated with IPV exposure disrupts normal brain functioning, leading to structural and functional changes in key cognition and emotional regulation areas. These changes often manifest as lower IQ scores, attention and memory deficits, and difficulties with academic performance. Understanding these impacts highlights the importance of early intervention and supportive care for children exposed to IPV to mitigate long-term cognitive and emotional consequences.

6.3 There is an Overlap Between Exposure to IPV and Direct Violence Against a Child

a) Connections Between Witnessing Intimate Partner Violence and Direct Violence

Research consistently demonstrates that children who witness intimate partner violence (IPV) are at heightened risk of experiencing direct violence, whether in the form of child abuse, later involvement in violent relationships, or becoming perpetrators of violence themselves. The connection between witnessing IPV and experiencing or perpetuating violence is rooted in multiple factors, including the psychological impacts of trauma, learned behavior patterns, and disrupted attachment systems.

b) Witnessing IPV and the Risk of Child Abuse

Children who witness IPV are significantly more likely also to experience direct physical, emotional, or sexual abuse. Studies show that in homes where IPV occurs, the rates of co-occurring child abuse range between 30% and 60% (Edleson, 1999). This overlap between IPV and child abuse suggests a strong association, as the dynamics of power, control, and aggression that characterize IPV can easily extend to abusive behaviors toward children.

- **Spillover of Violence:** In households where IPV is present, the aggression may not be limited to the intimate partners. Research has shown that abusers often direct their violence toward children as part of broader patterns of domination or in moments of heightened stress (Appel & Holden, 1998). This dynamic creates an environment where children are both witnesses and direct victims of violence.
- **Increased Parental Stress:** Parental stress, often exacerbated by IPV, is another factor that increases the likelihood of child abuse. Parents dealing with the trauma and tension of IPV may have reduced emotional and physical resources to care for their children, leading to neglect or abuse as a result of emotional dysregulation or frustration (Jaffee et al., 2007).

c) Emotional and Behavioral Impacts

Children exposed to IPV are at risk of developing emotional and behavioral issues that, in turn, increase their likelihood of becoming victims of direct violence. Chronic exposure to violence creates a cycle of emotional dysregulation, anxiety, and aggressive behavior, which can make children more vulnerable to being targeted for abuse in various contexts, such as school, their peer group, or future relationships.

- **Emotional Regulation:** The chronic stress associated with witnessing IPV disrupts normal emotional regulation, leading children to struggle with controlling their emotions and responding appropriately to stress (Margolin & Gordis, 2000). This dysregulation can manifest in behavioral problems, including aggression or withdrawal, both of which are risk factors for direct victimization.
- **Attachment and Trust Issues:** Exposure to IPV often leads to disrupted attachment relationships between children and their caregivers. Children may learn to associate love with violence, leading to confusion about healthy relationships. This disrupted attachment makes them more susceptible to victimization because they may have difficulty discerning abusive dynamics in relationships, both during childhood and in adulthood.

d) **IPV Exposure and Later Violent Relationships**

Children who witness IPV are more likely to experience violence in their romantic relationships as adolescents and adults. This pattern is known as the intergenerational transmission of violence, wherein exposure to violence during childhood normalizes aggression and abusive behavior in intimate relationships. Research shows that individuals exposed to IPV during childhood are more likely to be involved in violent relationships, either as victims or perpetrators, compared to those who did not witness IPV (Ehrensaft et al., 2003). Effects of IPV, which may result in later violent relationships, include:

- **Normalization of Violence:** Children who witness IPV may internalize the belief that violence is a normal and acceptable part of intimate relationships. This learned behavior can manifest in future relationships, where they may tolerate violence or resort to it as a conflict resolution strategy (Capaldi et al., 2012).
- **Risk for Perpetration:** Boys who witness IPV are particularly at risk for becoming perpetrators of violence in their adult relationships. Studies have shown that men who grew up in households where IPV was present are significantly more likely to engage in violent behavior toward their partners (Whitfield et al., 2003). The modeling of abusive behavior by a father or male figure plays a significant role in shaping these future patterns of behavior.
- **Self-Esteem and Vulnerability:** Exposure to IPV can negatively affect a child's self-esteem and sense of self-worth. Children who grow up in violent homes may internalize feelings of guilt, shame, and inadequacy, which can carry into adulthood. These low self-esteem issues make individuals more vulnerable to entering abusive relationships, as they may feel unworthy of healthy, respectful treatment (Whitfield et al., 2003).
- **Trauma Bonding:** Trauma bonding, a phenomenon where strong emotional attachments form between a victim and their abuser, is more likely to occur in individuals who experienced IPV in childhood. This attachment pattern can lead them to stay in abusive relationships despite recognizing the harmful dynamics, perpetuating the cycle of victimization (Freyd, 2008).

The connection between witnessing intimate partner violence and experiencing direct violence is well-established in research. Children exposed to IPV are at greater risk of experiencing child abuse, developing emotional and behavioral issues that increase vulnerability to victimization, and engaging in or being victimized by violence in their own

relationships later in life. The cycle of violence that begins with witnessing IPV underscores the need for early intervention to break the intergenerational transmission of abusive behavior and to protect children from both immediate and long-term harm.

7. IMPACTS OF ADVERSE CHILDHOOD EXPERIENCES (ACES) ON BRAIN DEVELOPMENT

Adverse Childhood Experiences (ACEs), which include traumatic events such as abuse, neglect, and household dysfunction (e.g., witnessing domestic violence, substance abuse, or parental separation), have a profound impact on the developing brain. Research indicates ACEs can cause significant brain structure and function alterations, leading to long-term cognitive, emotional, and psychological consequences. Understanding the specific effects of ACEs on brain development is critical for both prevention and intervention efforts in at-risk populations.

7.1 ACES Negatively Impact Multiple Brain Areas

a) Key Impacts of ACEs on Brain Development

Exposure to ACEs activates the body's stress-response system, known as the hypothalamic-pituitary-adrenal (HPA) axis. When children experience chronic stress, the HPA axis is overstimulated, resulting in prolonged exposure to stress hormones, particularly cortisol. This excessive cortisol exposure disrupts brain development, especially in emotional regulation, learning, and memory areas:

- **Hyperarousal and Anxiety:** ACEs are linked to hyperactivity of the amygdala, the brain's fear and emotional processing center. Chronic hyperarousal of the amygdala leads to increased anxiety and a heightened sensitivity to stress, which persists into adulthood (Teicher et al., 2003).
- **Hippocampal Damage:** The hippocampus, critical for memory formation and emotional regulation, is susceptible to elevated cortisol levels. Children with high ACE scores often show reduced hippocampal volume associated with impairments in memory, learning, and emotional regulation (Sapolsky, 2000; Bremner, 2006).

b) Prefrontal Cortex Development

The prefrontal cortex (PFC), responsible for executive functions such as decision-making, impulse control, and emotional regulation, is another area of the brain negatively impacted by ACEs. Research shows that children who experience high levels of adversity exhibit underdevelopment of the PFC, leading to difficulties in regulating emotions and behavior, as well as problems with attention and impulse control:

- **Impaired Decision-Making:** Deficits in the PFC are associated with problems in decision-making and impulse control. Children exposed to ACEs may struggle to think ahead or assess the consequences of their actions, increasing the risk of behavioral issues and maladaptive coping mechanisms, such as substance abuse (De Bellis et al., 2009).

- **Reduced Cognitive Flexibility:** ACEs can impair cognitive flexibility or the ability to adapt to changing situations. This is linked to the underdevelopment of the PFC, making it harder for children to regulate their behavior or respond appropriately to new information (McEwen & Morrison, 2013).

c) **Impaired Brain Connectivity and Integration**

ACEs have been found to disrupt the integration of different brain regions, leading to impaired connectivity between the amygdala, hippocampus, and PFC. This impaired communication limits the brain's ability to process emotional information, leading to heightened emotional reactivity and reduced emotional regulation capacity:

- **Disrupted Emotional Regulation:** Impaired connectivity between the PFC and the amygdala makes modulating emotional responses difficult. This manifests in heightened emotional reactivity, mood swings, and difficulty calming down after emotional outbursts (Shonkoff et al., 2012).
- **Difficulty with Memory and Learning:** The disconnection between the hippocampus and other brain regions impacts memory processing and retention, leading to difficulties in academic settings. Children exposed to ACEs often show lower IQ scores and struggle with attention and learning (Anda et al., 2006).
- **Impact on Neural Pruning and Plasticity:** Neural pruning is the brain's process of eliminating unnecessary neural connections, allowing for more efficient functioning. During childhood, this process is critical for healthy brain development. ACEs can interfere with normal pruning, either leading to excessive pruning (resulting in cognitive deficits) or insufficient pruning (resulting in maladaptive neural networks that promote anxiety, impulsivity, or aggressive behavior) (Teicher & Samson, 2016).
- **Reduced Brain Plasticity:** ACEs reduce brain plasticity, making it more difficult for the brain to adapt to new experiences. This can impair learning, emotional adjustment, and the ability to recover from trauma (McEwen, 2012).

7.2 Long-Term Psychological and Behavioral Effects

The long term psychological and behavioral effects of ACEs include:

- **Mental Health Disorders:** Children who experience ACEs are at higher risk for developing mental health disorders such as depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders. This increased risk is partly due to the changes in brain structure and function caused by chronic stress and the emotional dysregulation resulting from impaired brain development (Felitti et al., 1998; Teicher et al., 2003).
- **Behavioral Problems and Aggression:** ACEs have been linked to a higher incidence of behavioral problems, including aggression, impulsivity, and conduct disorders. These behaviors are thought to result from both the direct impact of trauma on the brain and the maladaptive coping mechanisms developed in response to a chaotic or unsafe environment (Shonkoff et al., 2012).
- **Cognitive Impairments:** ACEs are associated with lower academic performance

and cognitive impairments, including reduced IQ and attention, memory, and problem-solving difficulties. These cognitive deficits are linked to structural changes in the hippocampus, PFC, and other key brain regions (Anda et al., 2006).

The impact of Adverse Childhood Experiences on brain development is profound and long-lasting. Exposure to chronic stress and trauma during critical periods of brain development leads to alterations in brain structure and function, particularly in areas involved in emotional regulation, memory, and executive functioning. These changes underlie many emotional, behavioral, and cognitive difficulties observed in individuals with high ACE scores. Early intervention and trauma-informed care are crucial in mitigating the harmful effects of ACEs on brain development and promoting resilience in affected children.

8. PSYCHOTHERAPY SUMMARIES

8.1 Clinical Summary: I.D., Age 9

I.D. entered psychotherapy treatment with this psychologist, Dr. Laura Petracek, on May 16, 2024. Presenting issues included living in a household where there was domestic violence, a recent move from Armenia, recent marital separation, a new home, and a new school. This report summarizes her treatment with this psychologist over the last several months.

The initial sessions focused on creating a safe and supportive environment where I.D. felt comfortable expressing her feelings and experiences. During these sessions, Dr. Petracek established trust by ensuring I.D. understood that this was a safe space where she could talk without fear of judgment or repercussions.

At nine years old, I.D. is starting to grasp the world around her, but the complexities of her situation may still be beyond her complete understanding. She resides in Alameda, California, having recently moved from Armenia, where she lived with her family, including her father.

Now, she lives with her mother and two siblings. As trust grew, the focus shifted to helping I.D. identify and express her emotions. Dr. Petracek introduced activities like drawing or using emotion cards to help I.D. articulate her feelings. Through these exercises, I.D. started expressing fear, sadness, and confusion.

Dr. Petracek noted that I.D. was quiet and gently acknowledged I.D.'s discomfort, reassuring her that it was okay to feel scared or unsure. In subsequent sessions, she began to share small details about her daily life, hinting at the tension experienced but not yet delving into specific incidents of violence.

I.D. described feeling “scared” at home in Armenia and “sad” when she heard her parents arguing. Dr. Petracek validated these emotions, explaining that feeling this way in such situations was normal. I.D. was also encouraged to express these feelings through art, which helped her express emotions. I.D. attended camp during the summer and is now enrolled in school.

When asked about her friends, she admits she doesn't have any, which might suggest feelings of isolation or withdrawal—common in children who have experienced trauma. I.D. primarily plays with her brother and sister, relying on them for social interaction and emotional support. In addition to aggression, children exposed to domestic violence may also display signs of withdrawal or social isolation. (Holden, 2003). This reliance on siblings is typical in families facing domestic violence, as children often turn to each other for comfort and safety. I.D.'s siblings play a crucial role in her life, providing her with the emotional support and social interaction she needs.

Next, Dr. Petracek introduced the concept of domestic violence, ensuring I.D. that it was not her fault. Research has shown that children who grow up in violent households are more likely to struggle with managing their emotions, which can lead to outbursts of anger, aggression, or withdrawal from social interactions. (Margolin, 2000)

I.D. demonstrated remarkable courage by discussing specific incidents, such as how she would hide or try to comfort her siblings during fights. Dr. Petracek praised I.D. for her bravery and emphasized that her role was to keep herself safe. I.D. was reassured that it was okay to feel scared, and Dr. Petracek validated her feelings.

I.D.'s close relationship with her mother, characterized by their shared love for playing and singing, plays a crucial role in her emotional development. However, she admits to feeling scared of her father, revealing the lingering trauma from her past.

With a better understanding of her emotions and the situation at home, I.D. was introduced to coping strategies. Dr. Petracek taught I.D. deep breathing exercises, grounding techniques, and the importance of having a “safe space” where she could go when feeling overwhelmed. These psychological effects are often compounded by the child's inability to process and understand the violence they witness, leading to feelings of confusion, fear, and helplessness (Edleson, 1999). These coping strategies have been instrumental in helping I.D. manage her emotions and feel more in control of her reactions to stressful situations.

I.D.'s daily life includes attending school, and while she describes a typical after-school routine of having a snack, the violence she has witnessed at the hands of her father have caused a sense of disruption. Flashbacks, anxiety, and fear are psychological effects that are often exacerbated by the child's inability to process and understand the violence they witness, leading to feelings of confusion, fear, and helplessness (Edleson, 1999).

I.D. feels comfortable in her new home, stating that she feels safe. However, she still harbors fears about her father finding them. In subsequent sessions, I.D. shared that she witnessed her father throw and break things and has heard him use demeaning language, including frequently using the “F” word. I.D. stated in several sessions that her Papa had slapped her in the face. When asked if he used an open hand, she nodded yes. I.D. has also admitted to feeling scared during her parents' arguments, a common reaction for children exposed to domestic violence.

I.D. stated she has witnessed her father's violence towards their mother. She recounted seeing him slap Ms. Dias, hit Ms. Dias, and slam Ms. Dias's head on the floor. These traumatic observations have had a severe psychological impact, manifesting in symptoms of trauma and post-traumatic stress disorder (PTSD). According to a study published in the Journal of Interpersonal Violence, children who are exposed to domestic violence are more likely to exhibit symptoms of PTSD, including nightmares, flashbacks, and heightened anxiety levels (Fantuzzo & Mohr, 1999).

Despite the trauma, I.D. has not spoken to any other adults about the violence, likely due to fear or a belief that no one can help. The focus shifted to building resilience and reinforcing I.D.'s support network. Dr. Petracek encouraged I.D. to identify positive aspects of her life, such as friendships, hobbies, or school activities, that could provide comfort and stability.

I.D. also has obsessive-compulsive disorder. At the time of her initial presentation, I.D. was referred for psychological intervention due to symptoms indicative of obsessive-compulsive disorder (OCD). Her parents reported that she had contamination obsessions, leading to compulsions like excessive handwashing and avoidance of contact with her siblings out of fear of germs. This fear also caused her to display rigid body positioning, difficulty getting dressed, and regression in behaviors, including increased dependence on her mother.

I.D. also struggled with anxiety during the COVID-19 pandemic, which impacted her social skills and ability to adapt to online learning. Trauma and anxiety induced by witnessing domestic violence can contribute to the development of OCD in children as their brains and behaviors adapt to cope with the intense stress and fear associated with their environment.

Before therapy, I.D. struggled with creativity, mainly writing, and often sought guidance on what to create. She was also usually reluctant to discuss her day or share her thoughts.

She shows significant improvement, independently engaging in creative activities like crafting and starting her comic book. She is much more open, eagerly sharing details about her day and being more receptive to new experiences.

8.2 Clinical Summary: N.D., Age 8:

Like her sister I.D., N.D. started therapy on May 16, 2024. She initially hesitated to speak, often looking down or avoiding eye contact. Dr. Petracek noted these behaviors and gently acknowledged I.D.'s discomfort, reassuring her that it was okay to feel scared or unsure. Soon, she began to share small details about their daily lives, hinting at the tension she experienced but not yet delving into specific incidents of violence.

N.D. Dias, an eight-year-old girl, faces are evident in her everyday life as she navigates the emotional and psychological effects of recent upheavals.

N.D. is spent her summer at camp until school started in mid-August. This change in routine likely stems from her family's relocation to the United States. When asked about her social interactions, N.D. reveals a sense of isolation, stating that she has no friends at the camp.

Instead, she plays exclusively with her siblings, I.D. and C.D.. This reliance on her siblings for social interaction is common in families affected by domestic violence.

In early January 2024 (in Armenia), N.D. needed to go to a dentist; her parents were worried about a cavity that may require the tooth to be pulled out. After the dentist visit, N.D. stated that her father screamed at her, and ever since that day, N.D. had refused to eat any amount of sugar—even at birthday parties and even for her own birthday.

N.D.'s daily life revolves around simple routines, such as attending camp and having a snack after returning home. These activities may provide a semblance of normalcy but are overshadowed by the emotional turmoil she is still processing.

When asked about her emotional well-being, N.D. mentions that she likes their new house, suggesting that it might be a safer and more stable environment compared to her previous home. Importantly, N.D. feels secure in her new home, a critical factor in her recovery and emotional stability. Nevertheless, N.D. worries that her father might find them, indicating that the threat he poses still looms large in her mind.

N.D. relies heavily on her mother for emotional support, as seen in her response to whom she talks to when she is happy or sad. This reliance is vital, providing her security during a turbulent time.

N.D.'s emotional turmoil becomes apparent when discussing her parents' arguments. She describes freezing in response to their fights, a reaction common among children who experience domestic violence. Children who witness domestic violence may struggle with trust, intimacy, and emotional expression, leading to difficulty maintaining healthy and fulfilling partnerships (Ehrensaft et al., 2003). This sense of helplessness is reinforced by her decision not to intervene during these conflicts, showing the deep fear and anxiety she feels.

The violence in her home, including her father hitting her mother and breaking objects, has left a profound impact on her. N.D. stated that her father had hit her. When asked how? She said, "He slapped my face." "With an open hand?" "Yes." Casimiro also subjected her to emotional abuse by confining her and her siblings in a closet or locking them in a bathroom as punishment.

These traumatic experiences have left N.D. emotionally guarded, making it difficult for her to express her feelings. According to a study published in the *Journal of Interpersonal Violence*, children who are exposed to domestic violence are more likely to exhibit symptoms of PTSD, including nightmares, flashbacks, and heightened anxiety levels (Fantuzzo & Mohr, 1999).

Her reluctance to talk to other adults about the violence in her home may stem from fear, shame, or a belief that no one can help. This silence can prolong her suffering, making it harder for her to receive the support she needs.

Before therapy, she expressed deep sadness and troubling thoughts, including wishing she did not exist. In contrast, she now appears happy and carefree and even expresses

gratitude for being alive in her journal. N.D. better understands her emotions, learned effective coping strategies, and created a safety plan. In addition, as described above, N.D. had a self-imposed a strict no-sugar policy after her father reprimanded her following a dentist appointment in January 2024. Since therapy, she has allowed herself to enjoy sugary treats in moderation, showing a more balanced approach to her diet.

8.3 Clinical Summary: C.D., Age 6.

Summary of C.D.'s Therapy: May 16, 2024 to present

At first, C.D. hesitated to speak, often looking down or avoiding eye contact. Dr. Petracek noted these behaviors and gently acknowledged C.D.'s discomfort, reassuring him that it was okay to feel scared or unsure.

C.D.'s life has been marked by profound trauma, starting with the physical abuse he and his siblings endured at the hands of their father, Casimiro. He slapped them across the face multiple times, leaving them with deep-seated fear and anxiety that continues to affect I.D.'s overall well-being.

The impact of these abuses is not just limited to what was directly inflicted upon him; he also witnessed his father physically assaulting his mother, including slapping her and violently hitting her head on the floor. Such traumatic events have deeply affected his psychological state, leaving her with symptoms that align with post-traumatic stress disorder.

According to a study published in the Journal of Interpersonal Violence, children who are exposed to domestic violence are more likely to exhibit symptoms of PTSD, including nightmares, flashbacks, and heightened anxiety levels (Fantuzzo & Mohr, 1999). His continued exposure to this hostile environment only exacerbates these psychological wounds, threatening to cause long-term mental health issues.

C.D. also struggles with a learning disability, which the previous stressful home environment exacerbated due to the constant fear and anxiety he experienced.

C.D. continues to struggle with concentration and retaining information, but he has made excellent progress, making his speech mostly intelligible by May 2022. Minor residual errors were noted, including difficulties with the /r/ and /th/ sounds and mild vowel distortions. A recent reassessment during two teletherapy sessions confirmed that C.D.'s speech and language skills are solid and mature for his age, with no significant concerns.

C.D. often appears under duress, particularly when discussing his father, a possible indication of the ongoing impact of trauma on his behavior and interactions.

The violence experienced was not limited to physical aggression; Mr. Dias also subjected C.D. to emotional abuse by confining him and his siblings to a closet or locking them in a bathroom as punishment. These traumatic experiences have left C.D. emotionally guarded, making it difficult for him to express his feelings.

These traumatic observations by C.D. have had a severe psychological impact, manifesting in symptoms of trauma and post-traumatic stress disorder. According to a study published in the Journal of Interpersonal Violence, children who are exposed to domestic violence are more likely to exhibit symptoms of PTSD, including nightmares, flashbacks, and heightened anxiety levels (Fantuzzo & Mohr, 1999).

C.D. remains firmly attached to his mother and siblings. The narrative of C.D. illustrates the profound and lasting impact of domestic violence on children. The stress and trauma children experience at home can interfere with their ability to concentrate and perform well in school (Shonkoff & Garner, 2012).

When therapy began, C.D. initially exhibited negativity, anger, and aggression. However, since being in treatment, he has generally been more agreeable and displays moments of pure joy and excitement.

8.4 Clinical Conclusion

All three children displayed emotional and psychological symptoms typical of children exposed to IPV and domestic violence. Their BASC-3 assessments revealed low self-esteem, feelings of unworthiness, and difficulty forming friendships outside their family unit. The therapy helped each child develop coping mechanisms, gradually improving their emotional health and behavior, though the long-term effects of trauma still need careful monitoring.

The evaluation concluded that the children would be at strong risk of emotional and psychological harm if returned to their father's care, where exposure to the abusive environment could continue. The clinical findings support ongoing therapy and protective measures for the children to ensure their well-being.

9. ASSESSMENT OF MS. DIAS

To understand the alleged violence perpetrated by Mr. Dias against the Children and in the presence of the Children, I conducted a psychological assessment of Ms. Dias, who recounted the events leading up to her flight with the Children to the United States.

In my professional opinion, Ms. Dias' allegations of domestic abuse by Mr. Dias are credible.

Specifically, Ms. Dias explained that:

- On Monday, April 15, 2024, Mr. Dias forced Ms. Dias to call her parents and then proceeded to berate her parents and her on a long phone call.
- On Friday, April 19, 2024, Mr. Dias confiscated the Ms. Dias phone, read old text messages, and then became violent. He then kept her phone for three days, took screenshots of messages, and sent the screenshots to himself.
- On Sunday, April 21, 2024, while at a birthday party with the Children, Mr. Dias sent threatening messages to Ms. Dias, demanding she leave the house and threatening violence if she did not comply. Under threat from Mr. Dias of violence, Ms. Dias was not allowed to return to the home for three days.
- The same day, Ms. Dias went to the hospital for a CT scan and examination, which

led to police involvement.

- On the same day, and after being examined at the hospital, Ms. Dias was contacted by the Armenian police for a domestic violence report.
- Ms. Dias then reported the incidents to the US Embassy and was issued emergency passports for herself and her children.
- Ms. Dias secured legal assistance and testified to the police in Armenia, and an Emergency Restraining Order was issued effective April 22, 2024.
- Early on the morning of April 26, 2024, Ms. Dias fled to the United States with the children. Since leaving, Ms. Dias has initiated no contact with Mr. Dias.

To assess the frequency and severity of conflict in Mr. and Ms. Dias's relationship and assess the impacts on the children, I administered the Conflict Tactics Scale to Ms. Dias. The Conflict Tactics Scale (Straus 1979, 1990) measures the extent to which partners in a relationship engage in concrete acts and events of psychological, physical, or sexual attacks on each other; the consequences of the attacks; and partners' use of reasoning or negotiation to deal with conflicts.

Through this assessment, the following behaviors by Mr. Dias were identified:

- **Psychological Aggression:**
 - **Insults and Swearing:** Reported almost daily.
 - **Threats of Harm:** Reported several times a week.
 - **Destroying Property:** Reported a few times a month.
- **Physical Assault:**
 - **Pushing and Shoving:** Reported several times a week.
 - **Slapping or Hitting:** Reported a few times a week.
 - **Choking or Strangling:** Reported at least once a month.
 - **Use of Weapon:** Threatened reportedly at least once with a knife, creating significant fear and trauma.

The severity of the conflict and violence was assessed based on the impact on Ms. Dias's physical and psychological well-being:

- **Physical Injuries:**
 - **Bruises and Contusions:** Frequently observed after physical assaults. Rula's injuries were so severe that she was hospitalized on April 21, 2024.
 - **Cuts and Scrapes:** Reported occasionally.
 - **Serious Injuries (e.g., fractures):** At least one incident requiring medical attention.
- **Psychological Impact:**
 - **Fear and Anxiety:** Rula reported constant fear for her safety and the safety of her children.
 - **Depression:** Persistent feelings of sadness and hopelessness.
 - **PTSD Symptoms:** Frequent flashbacks, nightmares, and hypervigilance related

to the abuse.

The Conflict Tactics Scale results for Ms. Dias indicate a high frequency and severity of conflict and violence in her relationship with Casimiro. In my professional opinion, the reported behaviors suggest significant physical, psychological, and emotional harm to both Ms. Dias and the Children.

MMPI 3: Ms. Rula Dias SUBSTANTIVE SCALE INTERPRETATION

This section describes the test taker's clinical symptoms, personality characteristics, and behavioral tendencies and organizes them according to an empirically guided framework. Statements containing the word "reports" are based on the item content of MMPI-3 scales, whereas statements that include "likely" are based on empirical correlates of scale scores. Specific sources for each statement can be viewed using the annotation features of this report.

Somatic/Cognitive Dysfunction

This protocol does not indicate somatic or cognitive dysfunction. However, because of earlier indications of under-reporting, such problems cannot be ruled out.

Emotional Dysfunction

The test taker reports a lack of positive emotional experiences and a lack of interest. She likely presents with anhedonia. Her low reported level of activation may be linked to this affective pattern.

Thought Dysfunction

This protocol does not indicate disordered thinking. However, because of earlier indications of under-reporting, such problems cannot be ruled out.

Behavioral Dysfunction

This protocol does not indicate maladaptive externalizing behavior. However, because of the underreporting described earlier, such problems cannot be ruled out.

Interpersonal Functioning Scales

The test taker reports being unassertive. She reports not enjoying social events and avoiding social situations. She likely is socially introverted, has difficulty forming close relationships, and is emotionally restricted.

DIAGNOSTIC CONSIDERATIONS

Emotional-Internalizing Disorders

- Anhedonia-related disorders

Interpersonal Disorders

- Features of personality disorders involving detachment

- Disorders associated with social avoidance, such as avoidant personality disorder

10. PSYCHOLOGICAL ASSESSMENT OF I.D., N.D., AND C.D.

10.1 Physical Abuse

Each child expressed that Mr. Dias had slapped them on the face with an open hand numerous times. This physical abuse has instilled a deep sense of fear and anxiety in the children, impacting their overall well-being. Each child also stated that they saw their Papa hit their mother, slap her, and even hit her head on the floor.

For example, when asked whether her parents ever get hurt when they argue, N.D. said "Papa hits my Mommy." When asked whether anyone ever throws or breaks things when they argue, N.D. said my "Papa throws things, dishes, and breaks things." She also stated that "my Papa uses the F word a lot." Witnessing physical violence between their parents is profoundly traumatic for the Children and likely contributes to their feelings of fear and anxiety.

10.2 Emotional or Psychological Abuse

The Children have expressed that Mr. Dias placed them in a closet for hours as punishment or locked them in a bathroom. Children who witness domestic violence are significantly affected by emotional and psychological abuse, leading to a range of detrimental outcomes. Exposure to domestic violence disrupts their sense of safety and security, which is crucial for healthy emotional development.

1. **Emotional Dysregulation:** Children exposed to domestic violence often struggle with regulating their emotions. They may experience heightened anxiety, aggression, and mood swings as the chaotic environment prevents them from developing healthy coping mechanisms. This emotional dysregulation can lead to difficulties in social interactions and relationships later in life.
2. **Impact on Attachment:** Witnessing violence can severely disrupt attachment processes. Secure attachment with caregivers is essential for emotional stability; however, when children see one parent victimized or feel unsafe, their ability to form secure bonds is compromised. This can result in insecure attachments and difficulties trusting others.
3. **Cognitive and Behavioral Issues:** Research indicates that children who witness domestic violence are at a higher risk for cognitive impairments and behavioral problems. They may exhibit difficulties in concentration and learning, manifesting in academic challenges (Kitzmann et al., 2003). Behavioral issues may include increased aggression and defiance, as children may imitate the violent behavior they observe.
4. **Long-term Psychological Effects:** The emotional abuse experienced by these children can have lasting implications, contributing to conditions such as depression, anxiety disorders, and post-traumatic stress disorder (PTSD).
Intergenerational Effects: The emotional and psychological effects of witnessing domestic violence can perpetuate cycles of abuse. Children who grow up in such

environments may be more likely to become involved in abusive relationships as adults, either as victims or perpetrators, continuing the cycle of violence (Whitfield et al., 2003).

10.3 The Children's Relationship with Mr. and Ms. Dias

When asked, "How do you feel when you are with your Mommy or Papa," N.D. responded, "I like being around Mommy, but sometimes, I feel scared of Papa." When asked whether there are "things that make you happy or sad about being with [Mommy and Papa]," N.D. responded, "I'm so glad playing games with Mommy. I used to play with Papa, too." Her reference to past activities with her father suggests there were good moments, but these might be overshadowed by fear and the violence she witnessed.

I.D. and N.D. both expressed feeling unsafe "with Papa." C.D. stated that he did not feel unsafe. When asked about their father, I.D. said she "plays [with him] sometimes." N.D. mentioned, "he yelled at me because I had a cavity," indicating that even minor issues result in harsh reactions from their father. C.D. simply stated, "he's my Papa," which may reflect confusion or a desire to avoid speaking negatively about him.

When asked whether she feels safe at home, I.D. responded, "Where I live now, yes." This response indicates that her living environment is significantly safer than her previous one. Feeling secure at home is essential for a child's emotional and psychological well-being, especially after experiencing domestic violence. However, even in a safer environment, the trauma from past experiences can linger, leading to ongoing anxiety and hypervigilance.

10.4 Clinical Assessment and Concerns

In addition to interviews with the Children, I conducted a series of psychological assessments. One of the main tests for children of domestic violence survivors is the BASC 3, which looks at symptoms of children who have been abused, and each of the Children does have symptoms of trauma. These include symptoms of post-traumatic stress disorder ("PTSD"), anxiety, excessive worrying, isolation, and fear. The assessments I conducted on the Children are evidence-based and focus on objective questions to avoid potential or actual bias. That is, I do not use directive questions (e.g., "Are you afraid of your parent?") but instead use objective questions (e.g., "Do you ever feel sick?") to make the appropriate assessment.

This section details the results of these assessments and provides an overview of other clinical concerns for each child.

a) I.D.

(i) Obsessive Compulsive Disorder

I.D. has been diagnosed with Obsessive Compulsive Disorder ("OCD"). At the time of her initial presentation, I.D. was referred for psychological intervention due to symptoms indicative of OCD. Her parents reported that she had contamination obsessions, leading to compulsions like excessive handwashing and avoidance of contact with her siblings out of

fear of germs. This fear also caused her to display rigid body positioning, difficulty getting dressed, and regression in behaviors, including increased dependence on her mother. I.D. also struggled with anxiety during the COVID-19 pandemic, which impacted her social skills and ability to adapt to online learning.

I.D. was first assessed on April 10, 2022, using the Children's Yale-Brown Obsessive Compulsive Scale, scoring 37, which indicated severe OCD symptoms. She underwent seven sessions of therapy, including Exposure and Response Prevention Therapy, where she gradually learned to manage her compulsive behaviors. Throughout the treatment, I.D. showed improvement, with reduced aggression towards her siblings, better tolerance of germs, and decreased compulsive behaviors. However, therapy was disrupted during the summer of 2022 due to travel.

Currently, while I.D. is managing her OCD symptoms well, she struggles with verbal self-expression, decision-making, and social interactions. Therefore, it is recommended that she resumes individual therapy to address these ongoing concerns, improve her coping mechanisms, and regain independence in her decision-making process. If OCD symptoms re-emerge, a resumption of Exposure and Response Prevention Therapy is advised.

Obsessive-Compulsive Disorder (OCD) in children can be related to witnessing domestic violence through several pathways, primarily due to the heightened stress, anxiety, and trauma associated with living in a violent environment. Children who witness domestic violence often experience intense fear, helplessness, and insecurity, which can manifest in various psychological disorders, including OCD.

(ii) **BASC-3 Questionnaire Results**

I.D.'s BASC-3 Parental Relationship Questionnaire Report results indicate significant emotional and behavioral challenges. She displays high levels of anxiety, depression, and somatization, coupled with aggressive and hyperactive behaviors. Her adaptive skills, particularly in social interaction and communication, are deficient. These findings suggest a need for comprehensive support, including mental health intervention and strategies to improve adaptive skills and academic functioning.

I.D.'s BASC-3 Teacher Relationship Questionnaire Report indicates clinically significant symptoms of anxiety, including worry, nervousness, and fear. The results also indicate clinically significant symptoms of depression, including appearing withdrawn, pessimistic, and sad. The results also suggest that scores for I.D.'s adaptive skills, including social skills, leadership, study skills, and functional communication are all in the "At-Risk" range. Scores in the At-Risk range may identify a significant problem that may not be severe enough to require formal treatment or may determine the potential of developing an issue that needs careful monitoring.

b) **N.D.**

N.D.'s BASC-3 Parental Relationship Questionnaire Report indicates significant emotional and behavioral challenges. She displays high levels of anxiety, depression, and somatization, coupled with aggressive and hyperactive behaviors. Her adaptive skills,

particularly in social interaction and communication, are deficient. These findings suggest a need for comprehensive support, including mental health intervention and strategies to improve adaptive skills and academic functioning.

N.D.'s BASC-3 Teacher Relationship Questionnaire Report results highlight that while N.D.'s externalizing behaviors (hyperactivity, aggression, and conduct problems) are within the typical range for her age, she shows significant internalizing problems, especially in withdrawal, social skills, leadership, and functional communication. These findings suggest a substantial impact from witnessed domestic violence, manifesting primarily through anxiety, emotional distress, and significant social and adaptive challenges. Follow-up interventions are necessary to support N.D.'s emotional and social development and to address her communication difficulties.

c) **C.D.**

C.D.'s BASC-3 Parental Relationship Questionnaire Report results suggest that C.D. exhibits behaviors typical for his age in many areas, with some areas of concern. Externalizing problems such as hyperactivity and aggression are within usual ranges, but C.D.'s self-control and rule-following behaviors are reported to be similar to those of his peers. Internalizing problems such as anxiety, depression, and somatization also fall within the expected range, although C.D. reports frequent health-related issues.

In the Behavioral Symptoms Index, C.D. shows typical thought patterns but displays at-risk levels of withdrawal, suggesting potential social challenges that may require attention. However, attention problems are not a concern, as C.D.'s attention levels are typical for his age.

C.D.'s adaptive skills are generally substantial, particularly in leadership and functional communication, where he excels. However, social skills and adaptability are areas where C.D. could benefit from additional support to improve his interactions and adaptability to various situations.

C.D.'s BASC-3 Teacher Relationship Questionnaire Report findings suggest that C.D. displays a combination of typical behaviors and areas of concern. Externalizing problems such as hyperactivity, aggression, and conduct issues are within usual ranges, indicating that C.D.'s behavior in the classroom is generally calm and non-disruptive. However, further observation is needed if depression symptoms are present.

Internalizing problems, particularly anxiety, and somatization, are areas of concern, with C.D. displaying behaviors and health-related concerns that may suggest underlying emotional issues. These areas fall within the At-Risk classification and warrant careful monitoring.

Regarding school problems, C.D. maintains an appropriate level of attention and does not exhibit significant learning difficulties. However, in the Behavioral Symptoms Index, C.D. shows signs of atypicality and withdrawal, indicating potential social challenges and behaviors that may seem unusual or disconnected.

11. EFFECT ON THE CHILDREN OF IPV AND VIOLENCE AGAINST THE CHILDREN

11.1 Summaries of links between symptoms of Clinical Assessment for I.D., N.D., and C.D. and IPV/Violence against the children

a) I.D.

I.D., a 9-year-old girl, began weekly therapy with Dr. Laura Petracek on May 16, 2024, due to the traumatic experiences stemming from living in a household marked by domestic violence, recent relocation from Armenia, marital separation, and adjustments to a new school. Initial sessions focused on creating a safe space for I.D. to express her feelings. Dr. Petracek utilized drawing and emotion cards to help I.D. articulate emotions like fear, sadness, and confusion.

As trust developed, I.D. shared her experiences of fear at home, particularly during her parents' arguments, validating her emotions as normal reactions to distressing situations. Despite her initial silence regarding specific violent incidents, she demonstrated bravery by gradually revealing details of her father's aggression, including slapping and verbal abuse. I.D. BASC-3 symptoms show that she has developed PTSD, characterized by symptoms like hypervigilance, intrusive thoughts, nightmares, and flashbacks (Groves, 2002). This condition can persist into adulthood, complicating mental health and interpersonal relationships.

Dr. Petracek introduced coping strategies, such as deep breathing and grounding techniques, empowering I.D. to manage anxiety. I.D. also showed signs of Obsessive-Compulsive Disorder (OCD), which manifested as contamination fears leading to compulsive handwashing. Notably, therapy led to significant improvements in her creativity and openness about her daily experiences.

b) N.D.

N.D., 8, entered weekly therapy concurrently with her sister I.D.. Initially hesitant to speak, N.D. gradually shared her feelings of isolation, revealing that she relied on her siblings for social interaction. N.D. witnessed violence between parents or experienced direct abuse, which led to her anxiety and depression. Studies indicate that such children often feel helpless and fearful, increasing their vulnerability to mood disorders (Evans et al., 2008). She expressed fear stemming from her father's violent outbursts and emotional abuse. Notably, N.D.'s refusal to eat sugar after a traumatic dental experience illustrated the psychological impact of her home life.

Throughout therapy, N.D. began to express gratitude and positivity, marking a shift from deep sadness to a more carefree demeanor. She learned effective coping strategies, such as identifying safety plans, and began enjoying activities like writing, showcasing her emotional growth.

c) C.D.

C.D., aged 6, also began weekly therapy on May 16, 2024. His experiences of physical abuse from their father, Casimiro, compounded by witnessing violence towards his mother, left him with significant trauma symptoms, including potential PTSD. C.D. displayed learning difficulties exacerbated by his traumatic environment, affecting his concentration and retention skills.

Initially showing negativity and aggression, particularly towards authority figures. C.D. initially struggled to manage his emotions, leading to frequent emotional outbursts, prolonged sadness, or numbing of emotions (Margolin, 2005). C.D. progressed in therapy, exhibiting more agreeable behavior and moments of joy. His attachment to his mother and siblings provided crucial emotional support.

In conclusion, all three children, I.D., N.D., and C.D., exhibited symptoms of experiencing IPV and witnessing Domestic Violence. In addition to the individual symptoms, the children showed symptoms of fear and insecurity. Each of their BASC-3 scores reflected low self-esteem and feelings of unworthiness of love or safety. This stems from growing up in a chaotic, demeaning environment where they might internalize the violence as their fault (Holt et al., 2008).

Each child stated they don't yet have friends except for each other. Children who grow up in violent homes often struggle to form healthy relationships. They may have difficulty trusting others, fear intimacy, or replicate abusive patterns in their relationships as adults (Ehrensaft et al., 2003).

12. CONCLUSION

The effects of IPV and violence that I.D., N.D., and C.D. have experienced are pervasive, affecting their emotional, behavioral, cognitive, and social development. The clinical summaries of I.D., N.D., and C.D. illustrate the profound impacts of domestic violence on children. These impacts are complex and often interrelated, affecting a child's developmental trajectory, health, and future relationships. Therapy has facilitated their emotional expression, development of coping strategies, and improved interpersonal dynamics, highlighting the importance of support and resilience in overcoming trauma. In my professional opinion, based on the harmful effects of direct violence and exposure to IPV on children and my assessment of the Children, I conclude that the Children would be at risk of further—and potentially permanent—adverse effects to their development and psyche should they be forced to live in an environment (especially away from family and friends) where they could be subjected to violence against them or against their mother by their father for even a short period of time. .

13. PROFESSIONAL BACKGROUND

As a licensed psychologist with over 30 years of experience working with children affected by domestic violence, I have conducted numerous studies and clinical assessments on the long-term effects of trauma on child development. I completed my pre-doctoral internship at a Domestic Violence Treatment Program at Harborview Hospital in Seattle, Washington. My practice focuses on trauma-informed care, helping children and families recover from the psychological impacts of abuse and violence. My conclusions in this case are drawn

from direct observations during the interview and established research in child psychology and trauma.

Respectfully submitted,

Dr. Laura Petracek

Psychologist

Dated: September 23, 2024
Alameda, California

By: /s/ Laura Petracek

Dr. Laura Petracek

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EXHIBIT A

Laura Petracek Ph.D.

Clinical Psychologist

Laura Petracek Ph.D.

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Professional Licenses

Ph.D., Licensed Psychologist, PSY 20033
LCSW, Licensed Clinical Social Worker, LCS 16971

Education

California Institute of Integral Studies / Ph.D., Clinical Psychology
San Francisco, CA

Gestalt Associates for Psychotherapy / Gestalt Therapy
New York, NY

Yeshiva University, Wurzweiler School of Social Work / M.S.W., Honors,
Social Group Work
New York, NY

Hamline University / B.A., cum laude, Sociology
St. Paul, MN

**Minneapolis Community College / A.A., Chemical
Dependency Counseling**
Minneapolis, MN

Experience

Clinical

-
- Expertise in outpatient services, which included assessment of patients, individual and group treatment, family treatment, and aftercare planning
 - Strong clinical skills in psychosocial assessment, crisis intervention, counseling, interdisciplinary collaboration, and linkage with resources
 - Knowledgeable in child, adolescent, adult, and elder psychopathology
 - Expertise in psychiatric, psychosocial, substance misuse/abuse, and chemical dependency treatment.
 - Knowledgeable in DSM-IV-TR, family systems therapy, and crisis intervention models
 - Well versed in CBT / DBT skills and application in group

settings

- Expert in child, elder, and dependent adult abuse reporting requirements
- Knowledgeable of suicidal and homicidal behavior, and the skills necessary to assess lethality
- Expert in human behavior, communication, psychotherapy, case management, and the influence of cultural and spiritual values in psychotherapy
- Expert in providing psychosocial care appropriate to the age-specific needs of children, adolescents, and adults.
- Savvy in recovery-oriented services, family systems, and evidence-based treatments (e.g., Cognitive and Dialectical Behavioral Therapy, Motivational Interviewing, and Acceptance and Commitment Therapy)
- Demonstrates ability to communicate effectively, both verbally and in writing
- Experienced in interpersonal and organizational skills, to work effectively in a fast-paced environment with rapidly changing priorities and competing demands

Teaching

-
- Clear communicator and confident presenter to effectively instruct students in a way that is concise and understandable.
 - Strong organizational skills to ensure class information including syllabi, assignments, and other documentation is accessible and easy to understand.
 - Committed team player to work successfully with other faculty to establish course guidelines, modify curriculum, and set departmental goals.
 - Skilled understanding of technology and willing to learn about new software interfaces to enhance the learning experience of students
 - Maintain a class syllabus, assignment log, and additional material help for the students
 - Participate in weekly meetings with faculty to discuss departmental goals and upcoming events
 - Plan lectures, assignments, and in-field experiences to collaborate with necessary course curriculum
 - Collaborated with faculty staff to establish viable course curriculum and to make needed adjustments

**Forensic Treatment
/Psychological Testing**

- Expertise in violence/aggression reduction, domestic violence, and substance abuse treatment.
- Well versed in psychological assessments of sex offenders, domestic violence offenders, mentally disordered offenders (MDO), and Sexually Violent Predators (SVP); write up reports for court and appeared as an expert witness.
- Provide assessments of psychological disorders, level of dangerousness, and threat assessment.
- Skilled in Educational and Psychological testing of children/adolescents/adults.

**Work
History**

Psychologist / *Institute for the Advancement of Psychotherapy*

NOVEMBER 2020 - PRESENT, San Francisco, CA

Counseling Adults, adolescents and children using DBT, CBT for behavioral and emotional dysregulation.

School Psychologist / Oakland Unified School District

AUGUST 2015 - SEPTEMBER 2020, Oakland, CA

Conducted psychological assessments and interpreted results for students. Participated in IEP conferences, team meetings, and problem-solving meetings. Provided individual, group, and family therapy per IEP requirements.

Supervisor/ Psychologist / Center Point

JANUARY 2014 - AUGUST 2015, San Rafael, CA

Supervised line staff and Interns. Facilitated both Individual and Group therapy. Led seminars on 12 Step concepts.

Clinical Psychologist / San Quentin State Prison

APRIL 2007 - DECEMBER 2013, San Quentin, CA

Counseled inmates toward their goals in rehabilitation. Helped offenders develop relapse-prevention plans, offer educational programs, provide counseling and job skills

Contract Psychologist / California State Prisons

JULY 2005 - MARCH 2007, California

Provide rehabilitation to inmates, help them transition back into society.

Associate Professor, Psychology/ National University

APRIL 2003 - JUNE 2005, Sacramento, CA

Plan lectures, assignments, and in-field experiences to collaborate with the necessary course curriculum. Taught Graduate level courses in Marriage and Family track.

**Clinical Director / Women's Substance Abuse Services/New Leaf:
Services for Our Community**

JANUARY 1998 - SEPTEMBER 2003, Oakland, CA

Developed Internship training programs for LBGBT Community, LMFT and ASW interns. Conducted performance reviews for line staff Assisted practitioners by supervising complex cases.

Post-Doctoral Internship / Golden Gate Medical Examiners

SEPTEMBER 1996 - DECEMBER 1997, San Francisco, CA

Administered, scored, and documents results of psychological tests for SSI evaluations to highlight disability issues affecting employment.

Professor/Director / Addiction Training Center, Community College Of Southern Nevada

SEPTEMBER 1995 - AUGUST 1996, Las Vegas, NV

Developed Internship training programs for Addiction and Substance Use counselors. Taught classes on addiction, substance use, family systems, and harm reduction.

Pre-Doctoral Internship / Domestic Violence Treatment Program, Harborview Hospital

SEPTEMBER 1993 - AUGUST 1995, Seattle, WA

Interviewed and assessed potential clients for the Domestic Violence Treatment program. Expertise in providing Individual and Group therapy.

Clinical Supervisor / Personal Growth Center Northwest

SEPTEMBER 1989 - AUGUST 1993, Seattle, WA

Designed and implemented a Women's Substance Abuse program. Supervised both interns and clinical staff. Oversaw Internship training program.

Private Practice / Psychologist and LCSW

1987 - PRESENT, San Francisco, CA

Counseling adults, adolescents and children using evidence-based treatments and Gestalt Therapy

Clinical Social Worker/ Sheepshead Bay High School

AUGUST 1984 - AUGUST 1989, Brooklyn, NY

Designed counseling program for students with mental health and behavioral issues. Expert in-classroom support, consultation with teachers, parents, and administrators as well as providing individual and group counseling/therapy.

Workshops Presented

-
- Dialectical Behavioral Therapy for Alcohol and Drug Addiction: Cape Cod Symposium for Addiction Disorders: Hyannis, MA, September 7th, 2024
 - Dialectical Behavioral Therapy for Alcohol and Drug Addiction: Alameda County Psychological Association: UC Berkeley, March 16, 2024
 - Dialectical Behavioral Therapy for Alcohol and Drug Addiction: Pendle Hill, PA, April 23, 2023
 - Using Rap Music as a therapeutic connection: Creativity and Madness conference: Maui, HI 08/11
 - Beyond Patriarchy: New Approaches to Domestic Violence Treatment: Hilton Hotel, San Jose, CA 7/05
 - Anger and Women: Annual American Psychological

Association Conference, Honolulu, HI, 8/04

- Women Who Batter: Implications for Theory and Practice, presented at FAVTEA, Family Association
 - FAVTEA Training and Education Conference, Oakland, CA, 4/03
 - Effectively Addressing Anger in the Chemically Affected Client, Safeco
 - Corporation/Employee Assistants of Greater Seattle, Seattle, WA, 10/95 and 5/95
 - The Link Between Chemical Dependency and Domestic Violence, Group Health Cooperative, Seattle, WA, 10/93
 - Boundaries: Experiencing Your Power, Knowing Your Limits, Personal Growth Center Northwest, Seattle, WA, 3/95, 11/94
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Publications

- Petracek, L., DBT for Alcoholics and Addicts, JKP Publishers, 07/2022.
 - Petracek, L., An Anger Workbook for Women, New Harbinger Publications, 9/04.
 - Petracek, L. "Intervention in the Workplace," Counselor Magazine, July 1992
 - Petracek, L., "Intervention with Family Members," Recovery Newspaper, February 1992.
 - Petracek, L., "Boundaries: Experiencing Your Power, Knowing Your Limits," Journey Press, Vol II, No. 11, April 1991.
 - Petracek, L., "Healing Strategies for Couples and Families in Recovery," Journey Press, Vol II, No. 9, November 1990.
 - Petracek, L., "Women's Early Recovery Groups," Journey Press, Vol II, No. 4, April 1990.
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Professional Memberships

American Psychological Association, 1991-Present